Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: _____ B. WING _____	R-C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

RECEIVED
JAN 3 2018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Pitt County Department of Social Services conducted a follow-up survey and a complaint investigation on December 6-7, 2018. The complaint investigation was initiated by the Pitt County Department of Social Services on October 25, 2018.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION. Based on these findings, the previous unabated Type B Violation has not been abated. Based on observations, interviews and record reviews, the facility failed to schedule follow-up orthopedic care for 1 of 7 sampled residents (#2) who had fallen and obtained a fractured humerus. The findings are: Review of Resident #2's current FL-2 dated 02/12/18 revealed: -Diagnoses included hypertension, end stage renal disease, anemia with chronic renal disease,		Doctor's orders will be followed as prescribed. Starting immediately, weekly record reviews will be completed by the RCC (Resident Care Coordinator) or designee to ensure residents receive care as ordered by their physician. Record reviews will be on-going. Doctors will be notified regarding any physical/mental changes in the residents' condition. Documentation of this notification to physicians will be completed by the medication technicians/designee. Notification to the physician of these changes will be documented by the RCC/medication technicians and will be maintained in the residents' records. Any recommendations by the physicians will be documented in the residents' charts and will be followed accurately and timely. The RCC will immediately begin working with the staff on noted issues and concerns to ensure compliance with physicians' orders and that residents within the facility receive the care they need and deserve. The RCC will conduct an in-service with all medication aides on 12/10/2018 at 1:00 p.m. to re-train and reiterate the importance of following physician's orders. Furthermore, the RCC will be monitoring all orders that come into the facility for residents from inpatient visits, doctor's visits, phone orders, etc. to ensure all orders are noted and followed accurately.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula L. Mullins | TITLE: Administrator | (X6) DATE: 12-27-18

POC reviewed and accepted. Kim Olson, RN
01-07-19

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D 273	Continued From page 1 secondary renal hyperparathyroidism, obesity, dialysis patient, mental retardation, and osteoarthritis of both knees. -He was ambulatory with the use of a rollator walker. -There was an order for Tylenol 500mg take one tablet every six hours as needed for pain. Review of Resident #2's care plan dated 10/09/17 revealed: -The resident oriented and had adequate memory. -The resident was ambulatory and had no problems with his upper extremities. -The resident was independent with toileting, ambulation, and transferring. -The resident required limited assistance with eating, bathing, dressing and grooming by staff. Observation of Resident #2 on 12/05/18 at 11:40am revealed: -He was wearing a sling on his right arm. -He was walking down the hall using a rollator walker that he was holding on to with his left hand. Review of Resident #2's "Nurses Notes" revealed: -On 11/25/18 at 2:00pm the medication aide (MA) was called to Resident #2's room by a family member that indicated he needed assistance getting out of the chair because his arm hurt. -Resident #2 revealed he fell the day prior and that his shoulder was hurting him. -When asked if he wanted to go the ED, Resident #2 responded "yes". -The MA called 911 and the resident was transported to the ED. Review of Resident #2's Emergency Department	D 273		

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D 273	Continued From page 2 (ED) visit summary for 11/25/18 revealed: -Resident #2 had been seen in the ED for a fall. -Resident #2 had a fracture to his proximal humerus (arm). -Resident #2's arm was placed in a sling for comfort. -Follow-up would need to be arranged for Resident #2 with the orthopedic specialist. -Resident #2 may continue taking Tylenol as directed for pain. -If Resident #2 developed severely worsening pain, numbness or inability to move his arm, then medical attention should be sought promptly. -A call to the orthopedic specialist on 11/26/18 should be made for follow-up. Review of Resident #2's "72 Hour Acute Monitoring Report" revealed: -There was an entry by a second shift MA on 11/25/18 that read "Resident returned from hospital, had dinner, stayed up awhile then slept". -There was an entry by a third shift MA on 11/25/18 that read "Resident returned on second shift. He has a broken arm. There were no order changes for medications and no complaint from resident at this time". Review of Resident #2's Physician Office Visit summary dated 12/04/18 revealed: -Resident #2 was seen by his PCP for a follow-up appointment for hypertension on 12/04/18. -Resident #2 "was seen in the ED on 11/25/18 for a right humeral fracture and was to follow-up with orthopedics but has not". -"Please ensure patient takes his medications as ordered on his medication administration record (MAR) daily." -"Ensure patient is seen by orthopedics for his fracture; we will refer him today." -"Ensure patient has a follow-up CT scan	D 273		

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D 273	Continued From page 3 (computed tomography) and referral to orthopedic surgery". -Resident #2 should continue to wear his arm sling until he is seen by the orthopedic surgeon. Telephone interview with Resident #2's orthopedic provider on 12/05/18 at 4:00pm revealed: -Resident #2 did not have a referral appointment for follow-up for his fractured humerus. -There was no record of any phone call attempts made to the orthopedic provider to schedule an appointment for Resident #2. -Resident #2 had never been seen by the orthopedic provider. Interview with Resident #2 on 12/06/18 at 9:30am revealed: -He fell in the bathroom a few weeks ago and no one at the facility helped him. -He told a female staff member the day he fell and she "checked him out" and said he was fine. -The next day his arm was hurting and he told the staff and they sent him to the ED. -He came back from the hospital the same day and was told he had a broken arm and had to wear a sling. -The staff were supposed to make him an appointment to go back for a checkup but they had not done it yet. -He got someone to help him put on and take off the sling when he was getting dressed or bathed and sometimes he did it himself. -His arm continued to hurt since he fell and it currently hurt him. -He hoped he could go back to the doctor to get his arm examined. Interview with a medication aide (MA) on 12/06/18 at 10:00am revealed:	D 273		

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D 273	Continued From page 4 -On the morning (1st shift) of 11/25/18, Resident #2's family member called the MA asking for help in getting Resident #2 out of the chair. -Resident #2 could not push himself up out of the chair because his arm hurt. -She asked Resident #2 what was wrong with his arm and he said he fell the day before (11/24/18) and hurt his arm. -She then called 911 and the ambulance picked him up and took him to the ED. -She did not complete an incident report because she did not see him fall. -The process was to complete an incident report and fax it to the county and call the family and primary care provider (PCP) for any falls that required the resident to be sent to the ED. -There was a box in the medication room that staff placed all incident reports and nurses notes about the incident. -She had notified another family member (in addition to the one in the room) that Resident #2 was transferred to the ED. -She had not notified the PCP that the resident was transferred to the ED. -Because the Resident Care Coordinator (RCC) was there the day he was sent to the ED, she assumed that would suffice for reporting it. Interview with the RCC on 12/06/18 at 10:50am revealed: -Resident #2 was sent to the ED on 11/25/18 due to his arm hurting from a fall the previous day. -The family members were notified of his transfer the same day. -She did not complete an incident report because she did not see the fall. -She did not know that Resident #2 returned with paperwork from the ED requesting that a follow-up appointment be made with the orthopedic provider.	D 273		

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D 273	Continued From page 5 Interview with the transportation staff member and the RCC on 10/06/18 at 11:05am revealed: -They did not know that Resident #2 had returned from the ED with notes from the ED provider requesting a follow-up with the orthopedic provider. -The paperwork was filed in Resident #2's record and they had not seen it. -The process was that any paperwork accompanying the resident from the ED was left at the front desk and the MA on duty would look for new orders or changes to current care and then file the paperwork in the resident record. -If there were any new orders or changes, the MA was responsible to make those updates. -The transportation staff member was responsible for scheduling resident appointments if she was told by the MA or saw the request in the paperwork accompanying the resident. -Resident #2 had a routine appointment scheduled already for 12/04/18 with his PCP so the transportation staff member did not schedule another appointment. Interview with Resident #2's family member on 12/06/18 at 11:45am revealed: -The facility staff notified him whenever Resident #2 fell or had been sent to the ED. -The facility staff notified him a few weeks ago that Resident #2 had fallen the day before and was being taken to the ED that day due to him complaining of his arm hurting. -Resident #2 had returned from the ED with a sling and was told he broke his arm. -Since his fall, Resident #2 needed a lot of help to do things. -He did not know if Resident #2 had gone to the orthopedic provider for follow-up care. -He thought Resident #2 needed to wear the sling	D 273		

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D 273	Continued From page 6 until his arm healed and did not know of any other orthopedic appointments planned for Resident #2. Interview with a nurse from Resident #2's PCP's office on 12/06/18 at 12:15pm revealed: -Resident #2 was seen by the PCP on 12/04/18 for a follow-up appointment for hypertension. -Resident #2 was seen in the ED on 12/03/18 for chest pain. -They put in a referral request on 12/04/18 for Resident #2 to follow-up with the orthopedic provider and that request was still in "pending status" in their electronic documentation system. Interview with the Administrator on 12/06/18 at 2:30pm revealed: -She did not know Resident #2 had an order for a follow-up with the orthopedic provider. -The process was the MA on duty was responsible for any orders the resident had when returning from the ED or other appointments. -The MA would slip the paperwork under the RCC's door and the transportation staff member would schedule the follow-up appointment. -The paperwork for Resident #2 must have been filed in the resident record and not reviewed. -The facility policy was that all resident visits to the ED were followed up with a PCP appointment. -She would make sure Resident #2 had an orthopedic follow-up appointment as soon as possible. Interview with Resident #2's PCP on 12/06/18 at 3:50pm revealed: -Resident #2 was seen in her office on 12/04/18 for a follow-up appointment for hypertension. -Resident #2 was wearing a sling on his right arm. -Resident #2 expressed he was in pain and his	D 273		

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D 273	Continued From page 7 right arm was hurting him. -She had noted in Resident #2's electronic record that he had been seen in the ED on 11/25/18 for a fracture of his right humerus. -The ED instructions indicated that the orthopedic specialist was to have been contacted on 11/26/18 to arrange for a follow-up. -Resident #2 indicated he had not been back to the doctor for his arm. -The "sitter" that was with Resident #2 did not know if he had a follow-up appointment with the orthopedic specialist. -The PCP called the facility on 12/04/18 and the staff told her they did not know if Resident #2 had been for a follow-up visit or had an appointment with the orthopedic specialist. -Resident #2 should have seen an orthopedic surgeon for his fractured humerus so it could be assessed and determined if further intervention such as surgery would be needed. -The ED put on the sling to keep him from moving his arm, but it may need to be splinted and the orthopedic surgeon would determine that through x-ray studies. -If Resident #2 did not receive proper follow-up for his fractured humerus, it could result in frozen shoulder (a condition characterized by stiffness and joint pain) or if not healed correctly, he may permanently not be able to move his right arm. -Resident #2 had Tylenol ordered for his arm pain, but she was not sure if Resident #2 was getting any pain medication for his arm since it was not noted on his MAR. Interview with the RCC and two MAs on 12/06/18 at 4:00pm revealed: -There were no specific orders for Resident #2's splint. -They did not know how long to keep it on or remove it, so they kept it on him unless he was	D 273		

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D 273	Continued From page 8 bathing. -Resident #2 never asked for pain medication so they had not given him any. Interview with a personal care aide (PCA) on 12/06/18 at 4:10pm revealed: -Resident #2 wore his sling during the day and at night when he slept. -Resident #2's shower days were Monday, Wednesday and Friday on second shift. -She helped him take off his sling when he showered. -Resident #2 could not lift his right arm because it hurt him, so she would carefully help him slip off his shirt. -When Resident #2 was in the shower, he held his right arm next to his body because it hurt him to move it. -She had helped him shower on 12/05/18 and his right arm was hurting him during the shower. -He had not asked for any pain medication. -The MA's knew the resident's arm hurt him because the PCA heard him tell the staff. Review of Resident #2's MAR for November and December 2018 revealed Tylenol 500mg one tablet every six hours as needed for pain was ordered, but there was no documentation that it had been given. The facility failed to contact Resident #2's orthopedic provider and schedule a follow-up appointment for a fractured humerus obtained from a fall, as ordered upon discharge from the emergency department. Resident #2 had been without follow up care for eleven days which placed the resident at risk for frozen shoulder and permanent inability to move his arm if it did not heal correctly. This failure was detrimental to the	D 273		

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D 273	Continued From page 9 health of the resident and constitutes a continuing unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/18 for this violation.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure care and services related to health care referral and follow-up needs. The findings are: Based on observations, interviews and record reviews, the facility failed to schedule follow-up orthopedic care for 1 of 7 sampled residents (#2) who had fallen and obtained a fractured humerus. [Refer to Tag 0273 10A NCAC .0902(b) Health Care Unabated Type B Violation).]	D912	Doctor's orders will be followed as prescribed. Starting immediately, weekly record reviews will be completed by the RCC (Resident Care Coordinator) or designee to ensure residents receive care as ordered by their physician. Record reviews will be on-going. Doctors will be notified regarding any physical/mental changes in the residents' condition. Documentation of this notification to physicians will be completed by the medication technicians/designee. Notification to the physician of these changes will be documented by the RCC/medication technicians and will be maintained in the residents' records. Any recommendations by the physicians will be documented in the residents' charts and will be followed accurately and timely. The RCC will immediately begin working with the staff on noted issues and concerns to ensure compliance with physicians' orders and that residents within the facility receive the care they need and deserve. The RCC will conduct an in-service with all medication aides on 12/10/2018 at 1:00 p.m. to re-train and reiterate the importance of following physician's orders. Furthermore, the RCC will be monitoring all orders that come into the facility for residents from inpatient visits, doctor's visits, phone orders, etc. to ensure all orders are noted and followed accurately.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL074038	A. Building B. Wing	12/6/2018

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0034	Correction	ID Prefix D0270	Correction	ID Prefix D0355	Correction
Reg. # 10A NCAC 13F .0703(a)	Completed	Reg. # 10A NCAC 13F .0901(b)	Completed	Reg. # 10A NCAC 13F .0909	Completed
LSC	11/17/2018	LSC	10/07/2018	LSC	09/24/2018
ID Prefix D911	Correction	ID Prefix D914	Correction	ID Prefix	Correction
Reg. # G.S. 131D-21(1)	Completed	Reg. # G.S. 131D-21(4)	Completed	Reg. #	Completed
LSC	09/24/2018	LSC	10/17/2018	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Kim Olson, RN	12-17-18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/16/2018	☐ YES ☐ NO

EVENT ID SFVQ13

STATE FORM REVISIT REPORT (11/00)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
#7014 0150 0001 8987 2661

December 19, 2018

Paula Meekins, Administrator
Southern Living Assisted Care, LLC, Licensee
Southern Living Assisted Care
P.O. Box 7386
Greenville, NC 27834

email address: southernlivingpaula@yahoo.com

Re: Follow-up Survey and Complaint Investigation completed December 6, 2018 (SPVQ13 – 8FYS11/NC00143918)
Continuing Unabated Type B Violation

Facility:	**Southern Living Assisted Care**
Licensure Number:	**HAL-074-038**
County:	**Pitt**

Dear Ms. Meekins:

Thank you for the cooperation and courtesy extended during the survey completed December 6, 2018 by staff with the Adult Care Licensure Section and Pitt County Department of Social Services.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The Type B Violations in the rule areas of **10A NCAC 13F .0909 Resident Rights, 10A NCAC 13F .0901(b) Personal Care and Supervision** and **G.S. § 131D-21 Resident Rights** were abated as of the correction date, October 7, 2018. Therefore penaltieswill not be recommended.

Based on survey findings, the complaint allegation was not substantiated.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Unabated Type B Violations

- Continuing Unabated Type B Violation is cited for **10A NCAC 13F .0902(b) Health Care** and **G.S. § 131D-21 Resident Rights.**
- A correction date of January 5, 2019 has been provided. If on the follow-up, it is determined the facility has abated the Type B Violation, the penalty fine will stop for each violation as of the date you submit in writing.
- Information regarding any penalty recommendation and imposition for the violations will be mailed to you separately.

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation within the time specified for correction, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars ($400.00) for each day that the violation continues beyond the date specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **January 15, 2019**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **January 15, 2019**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 919-538-4847. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Kim Olson

Kim Olson, RN, BSN, M.Ed., Nurse Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Sharon Alexander, Adult Home Supervisor, Pitt County Department of Social Services
Suzy Morgan, Team Supervisor, East 5 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: http://www2.ncdhhs.gov/dhsr/customerservice.html
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)